MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Dr. D., D.C. 211 South Elm Weatherford, TX 76086	MDR Tracking No.: M4-04-3721-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Fidelity & Guaranty Insurance Box 19	Date of Injury: Employer's Name: Insurance Carrier's No.: 89941356056039

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
11/12/02	**12/20/02**	**99213-MP, 97014, 97112, 97110, and 97540,**	**$355.00**	**$0.00**

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary not submitted.

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 12/22/03 states in part, "…Carrier has previously responded to this dispute on 12/5/03. The provider has not submitted additional pertinent information and the carrier position remains the same."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- Per Rule 133.307(d)(1) date of service 11/12/02 was not filed in a timely manner and outside the jurisdiction of MDR and will not be reviewed.

- CPT Codes 99213-MP, 97014, 97112, 97110, and 97540 for dates of service 11/19/02 and 12/20/02. Neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor has not submitted convincing evidence (i.e. signed green card) of the provider request for an EOB. Reimbursement is not recommended.

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	01-28-05

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____